

**DEPARTMENT OF HEALTH AND MENTAL HYGIENE
OFFICE OF PROCUREMENT AND SUPPORT SERVICES
CONTRACT MANAGEMENT TOOL**

GENERAL INFORMATION		
Project Title: _____		Project Number: _____
Contract Term: _____ year(s) month(s)	Contract Amount: _____	
Contract File Location	Paper: _____	Electronic: _____
CONTRACT MONITOR		
Name: _____	Phone: _____	Email: _____
CONTRACTOR CONTACT		
Name: _____	Phone: _____	Email: _____
KEY PERSONNEL		
Contractor: _____		
Name: _____		
Title: _____		
Phone: _____	Email: _____	
KICK-OFF MEETING		
<input type="checkbox"/> Kick-Off Meeting	Where: _____	When: _____
Summary: _____		
<input type="checkbox"/> Review Contract and Scope of Work		

MINIMUM REQUIREMENTS, CERTIFICATIONS, ETC.				
Requirement	Expiration Date	Within Contract Term	Contacted for Renewal	Renewal Complete
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

INSURANCE	
<input type="checkbox"/> Insurance (If yes, please check all applicable Types and indicate corresponding Amounts in the table below.)	
Type	Amount
<input type="checkbox"/> Commercial General Liability	
<input type="checkbox"/> Bodily Injury	
<input type="checkbox"/> Property Damage	
<input type="checkbox"/> Personal and Advertising Injury Liability	
<input type="checkbox"/> Errors and Omissions	
<input type="checkbox"/> Professional Liability	
<input type="checkbox"/> Automobile	
<input type="checkbox"/> Commercial Truck	
<input type="checkbox"/> Employee Theft	
<input type="checkbox"/> Workers' Compensation	

INVOICES	
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[illegible]

[illegible]

MBE GOALS			
<input type="checkbox"/> MBE <div style="display: flex; justify-content: space-between; align-items: flex-start; margin-top: 10px;"> <div style="width: 45%;"> If yes, what is the goal? _____ % </div> <div style="width: 50%;"> <input type="checkbox"/> Subgoals (If yes, please identify subgoals below.) </div> </div>			
African American: %	Asian American: %	Hispanic American: %	Women: %

CONTRACTORS				
Vendor Name	Address	Contact Name	Phone	Email

VENDOR INVOICES							
Month	Vendor Name	MBE Invoice Received	If No, Vendor Contacted?	Prime Contractor Invoice Received	If No, Vendor Contacted?	Match	If No, Both Vendors Contacted?

VSBE GOALS	
<input type="checkbox"/> VSBE	
If yes, please enter the goal: _____ %	

CONTRACTORS				
Vendor Name	Address	Contact Name	Phone	Email

**DEPARTMENT OF HEALTH AND MENTAL HYGIENE
OFFICE OF PROCUREMENT AND SUPPORT SERVICES
PROGRAM/CONTRACTOR MEETING**

Date: _____

Contractor Name: _____

Contact Name: _____ **Title:** _____ **Phone:** _____ **Email:** _____

Reason for meeting:

Was issue resolved? ☐

If no, list next steps:

REPORTING REQUIREMENTS	
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